

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
03-14

2. STATE  
Nevada

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE  
August 13, 2003

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:

a. FFY 2004 \$ 00.00  
b. FFY 2005 \$ 00.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Page 1	Page 41	Page 71
Attachment 4.30, Page 2	Page 45(a)	Page 77
Page 9	Page 45(b)	Page 78a
Attachment 2.2-A, Page 10	Page 46	
Attachment 2.2-A, Page 10a	Page 50a	
Page 11	Page 55	

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

Page 1	Page 45(b)	Page 77
Page 9	Page 46	Page 78a
Attachment 2.2-A, Page 10	Page 45(a)	
Attachment 2.1-A	Page 71	
Page 50a	Page 41	
Page 55		

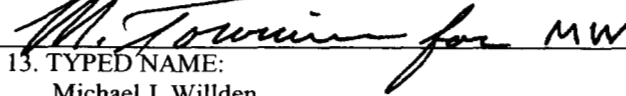
10. SUBJECT OF AMENDMENT: The specific changes being made in order to comply with all the Balanced Budget Act of 1997 regulations regarding managed care entities.

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Michael J. Willden

14. TITLE:

Director, DHR

15. DATE SUBMITTED:

9/29/03

16. RETURN TO:

John A. Liveratti, Chief  
DHCFP/Medicaid  
1100 East William Street, Suite 102  
Carson City, Nevada 89701

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

September 29, 2003

18. DATE APPROVED:

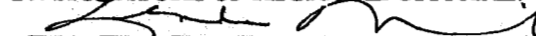
October 10, 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

August 13, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

Linda Minamoto

22. TITLE: Associate Regional Administrator  
Division of Medicaid & Children's Health

23. REMARKS:

State: NEVADA

## LIST OF ATTACHMENTS

<u>No.</u>	<u>Title of Attachments</u>
*1.1-A	Attorney General's Certification
*1.1-B	Waivers under the Intergovernmental Cooperation Act
1.2-A	Organization and Function of State Agency
1.2-B	Organization and Function of Medical Assistance Unit
1.2-C	Professional Medical and Supporting Staff
1.2-D	Description of Staff Making Eligibility Determination
*2.2-A	Groups Covered and Agencies Responsible for Eligibility Determinations
	* Supplement 1 - Reasonable Classifications of Individuals under the Age of 21, 20, 19 and 18
	* Supplement 2 - Definitions of Blindness and Disability (Territories only)
	* Supplement 3 - Method of Determining Cost Effectiveness of Caring for Certain Disabled Children at Home
*2.6-A	Eligibility Conditions and Requirements (States only)
	* Supplement 1 - Income Eligibility Levels – Categorically Needy, Medically Needy and Qualified Medicare Beneficiaries
	* Supplement 2 - Resource Levels – Categorically Needy, Including Groups with Incomes Up to a Percentage of the Federal Poverty Level, Medically Needy, and other Optional Groups
	* Supplement 3 - Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
	* Supplement 4 - Section 1902(f) Methodologies for Treatment of Income that Differ from those of the SSI Program

\*Forms Provided

TN # 03-14  
 Supersedes TN # 91-22

Effective Date 8-13-03  
 Approval Date OCT 10 2003

State: NEVADACitation

1932(e)

42 CFR 428.726

Sanctions for MCOs and PCCMs

- (a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:
- (1) civil penalties in the amounts specified in 42 CFR 438.704;
  - (2) appointment of temporary management for the contractor as provided in 42 CFR 438.706;
  - (3) granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll;
  - (4) suspensions of all new enrollments, including default enrollment, after the effective date of the sanction;
  - (5) suspension of payment for recipients enrolled after the effective date of the sanction until CMS or the State is satisfied that the reason for the sanction no longer exists and is not likely to recur; or,
  - (6) any additional sanctions allowed under State statute or State regulations that address areas of non-compliance specified in 42 CFR 438.700 as well as additional areas of non-compliance. Additional sanctions may include liquidated damages and imposition of plans of correction in addition to its remedies at law.

Before imposing any intermediate sanction, liquidated damages, plans of correction, or other remedy against a managed care entity, DHCFP shall provide the Contractor with notice and such other due process protections as the State may provide, except that DHCFP will not provide the Contractor with a pre-termination hearing before imposing the sanction described in SSA, Section 1932(e)(2)(B) (Temporary Management).

- (b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:

The State of Nevada may impose the optional sanction of temporary management if it finds through on-site survey, enrollee complaints, financial audits, or any other means that there is continued egregious behavior by the Contractor, including but not limited to behavior described in 42

State: NEVADACitation

1932(e)

42 CFR 428.726

Sanctions for MCOs and PCCMs

CFR 438.700 or that is contrary to any sections of 1903(M) and 1932 of the Act; or if there is substantial risk to the enrollees' health; or the sanction is necessary to ensure the enrollees' health while improvements are made to remedy violations of 42 CFR 438.700 or until there is an orderly termination of the contract.

- (c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

TN # 03-14  
Supersedes TN # N/A

Effective Date 8-13-03  
Approval Date OCT 10 2003

State: NEVADA

Citation 42 CFR 431.12(b) AT-78-90	1.4	<p>State Medical Care Advisory Committee</p> <p>There is an advisory committee to the Medicaid agency director on health and medical care Services established in accordance with and meeting all the requirements of 42 CFR 431.12.</p>
42 CFR 438.104		<p><input checked="" type="checkbox"/> The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.</p>

TN # 03-14  
 Supersedes TN # 74-50

Effective Date 8-13-03  
 Approval Date OCT 10 2003

State: NEVADA

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy

(Continued)

42 CFR 435.212 &  
1902(e)(2) Act,  
P.L. 99-272  
(Section 9517)  
P.L.101-508  
(Section 4732)

[N/A] 3. The State deems as of the eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO) or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

X The State elects not to guarantee eligibility.

\_\_\_ The State elects to guarantee eligibility. The minimum enrollment period is \_\_\_ months (not to exceed six).

The State measures the minimum enrollment period from:

[N/A] The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.

[N/A] The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

[N/A] The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

\*Agency that determines eligibility for coverage.

TN # 03-14  
Supersedes TN # 91-22

Effective Date 8-13-03  
Approval Date OCT 10 2003

State: NEVADA

Agency*	Citation(s)	Groups Covered
	B.	<u>Optional Groups Other Than Medically Needy</u> (Continued)
1932(a)(4) of Act		<p>The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.</p> <p>[N/A] Disenrollment rights are restricted for a period of _____ months (not to exceed 12 months).</p> <p>During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.</p> <p>[X] No restrictions upon disenrollment rights.</p>
1903(m)(2)(H), 1902(a)(52) of the Act P.L. 101-508 42 CFR 438.56(g)		<p>In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.</p> <p>[X] The agency elects to reenroll the above individuals who are eligible in a month but in the succeeding twelve months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.</p> <p>[N/A] The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.</p>

\* Agency that determines eligibility for coverage.

TN # 03-14  
Supersedes TN # N/A

Effective Date 8-13-03  
Approval Date OCT 10 2003

State: NEVADACitation

42 CFR

435.914

1902(a)(34)

of the Act

2.1(b) (1)

Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.

1902(e)(8) and

1905(a) of the

Act

(2)

For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month which the individual is first determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.

1902(a)(47) and

\_\_\_\_\_(3)

Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.

TN # 03-14Supersedes TN # 97-02Effective Date 8-13-03Approval Date OCT 10 2003

State: NEVADA

Citation	3.1(a)(9)	Amount, Duration, and Scope of Services: EPSDT Services (continued)
42 CFR 441.60	[N/A]	The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements. **
42 CFR 440.240 and 440.250		(a)(10) Comparability of Services
1902(a) and 1902 (a)(10), 1902(a)(52), 1903(v), 1915(g), and 1925(b)(4), and 1932 of the Act		Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915, 1925, and 1932 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:
		(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.
		(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.
		(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.
	[N/A]	(iv) Additional coverage for pregnancy-related service and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

\*\* Describe here.

The continuing care provider submits monthly encounter data reflecting the number of examinations completed the number of examinations where a referable condition was identified, and the number of follow-up treatment encounters. Medicaid staff makes periodic on-site reviews to monitor the provider's record of case management.

TN # 03-14  
Supersedes TN # 92-05

Effective Date 8-13-03  
Approval Date OCT 10 2003

State: NEVADACitation

## 4.10 Free Choice of Providers

42 CFR 431.51

AT 78-90

46 FR 48524

48 FR 23212

1902(a)(23)

P.L. 100-93

(Section 8(f))

P.L. 100-203

(Section 4113)

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy person, or organization that is qualified to perform the services, including of the Act an organization that provides these services or arranges for their availability on a prepayment basis.

(b) Paragraph (a) does not apply to services furnished to an individual –

(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act,

Section 1902(a)(23)  
Of the Social  
Security Act  
P.L. 105-33

(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services, or

Section 1932(a)(1)  
Section 1905(t)

(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c).

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a); or, managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905 (a)(4)(c).

TN # 03-14  
Supersedes TN # 92-10

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